

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

| | | |
|---|----------------------|---------------|
| Requestor's Name and Address: HARRIS METHODIST 3255 W PIONEER PKWY ARLINGTON TX 76013-4620 | MFDR Tracking #: | M4-07-3131-01 |
| | DWC Claim #: | |
| | Injured Employee: | |
| Respondent Name and Box #: Zurich American Insurance Company of Illinois Box #: 19 | Date of Injury: | |
| | Employer Name | |
| | Insurance Carrier #: | |

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider on CPT 29881 at the APC rate of \$1,670.39 for APC number 041. Allowing this at 140% would yield a fair and reasonable allowance of \$2,338.55."... "In addition Medicare would have reimbursed the provider for the second OR service, CPT 29877, at half the APC rate so they would allow \$835.20 for APC number 041. Allowing this at 140% would yield a fair and reasonable allowance of \$1,169.27."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - \$1,536.65
3. Hospital Bill
4. EOB
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Rule 133.307 requires a party requesting medical dispute resolution to include both the original and reconsideration EOBs in its request. Requestor failed to do so. The request should be dismissed and the Requestor be required to submit a complete request."

"The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that \$1,971.18 represents an amount greater than or equal to the fair and reasonable reimbursement for this service. The provider must therefore prove that the reimbursement received is not fair and reasonable."

"Carrier calculated the reimbursement based upon the DWC ASC Fee Guideline as a measure of Fair and Reasonable."...

"Because Requestor has failed to prove that the reimbursement received is not fair and reasonable, Requestor is not entitled to further reimbursement."

Principle Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

| Date(s) of Service | Denial Code(s) | Disputed Service | Amount in Dispute | Amount Due |
|--------------------|------------------|--------------------|-------------------|------------|
| 9/1/2006 | 97, 226, W1, 790 | Outpatient Surgery | \$1,536.65 | \$0.00 |
| Total Due: | | | | \$0.00 |

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
 - 226 – “Included in global charge.”
 - 790 – “This charge was reimbursed in accordance to the Texas medical fee guideline.”
 - 97 – “Payment is included in the allowance for another service/procedure.”
 - W1 – “Workers compensation state fee schedule adjustment.”
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §133.307(c)(2)(A), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include “a copy of all medical bill(s)”... “as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter”... This request for medical fee dispute resolution was received by the Division on January 18, 2007. Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier and as submitted for reconsideration. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(A).
5. Division rule at 28 TAC §133.307(c)(2)(B), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include “a copy of each explanation of benefits (EOB) relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB.” This request for medical fee dispute resolution was received by the Division on January 18, 2007. Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of the EOB detailing the insurance carrier’s response to the request for reconsideration. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(B).
6. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include “a position statement of the disputed issue(s) that shall include”... “how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues”... This request for medical fee dispute resolution was received by the Division on January 18, 2007. Review of the requestor’s position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(F)(iii).
7. Division Rule at 28 TAC §133.307(c)(2)(G) , effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable”. This request for medical fee dispute resolution was received by the Division on January 18, 2007. The requestor’s position statement asserts that “Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider on CPT 29881 at the APC rate of \$1,670.39 for APC number 041. Allowing this at 140% would yield a fair and reasonable allowance of \$2,338.55.”... “In addition Medicare would have reimbursed the provider for the second OR service, CPT 29877, at half the APC rate so they would allow \$835.20 for APC number 041. Allowing this at 140% would yield a fair and reasonable allowance of \$1,169.27.” Review of the requestor’s position statement finds that the requestor did not discuss or explain how it determined that 140% of the Medicare rate would yield a fair and reasonable reimbursement. Nor did the requestor

submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support the proposed methodology. Nor has the requestor discussed how the proposed methodology would be consistent with the criteria of Labor Code §413.011, or would ensure similar reimbursement to similar procedures provided in similar circumstances. Additionally, the requestor did not provide documentation, such as Medicare fee schedules, redacted EOBs, payment policy manual excerpts, or other evidence, to support the Medicare payment calculation. Review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that the payment amount sought is a fair and reasonable rate of reimbursement in accordance with 28 TAC §134.1. The request for additional reimbursement is not supported.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A), §133.307(c)(2)(B), §133.307(c)(2)(F)(iii) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.250, §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.